Billing Information Form
THE INTEGRAL PSYCHOLOGY CENTER

1. Client Information

Name____
Address___________________________ **City**____________**State**_____**Zip**_______
Home Telephone_____________________ **Work Telephone**_____________________
Cell Phone________________ **Date of Birth**_____________ **Soc. Sec. #**__________
Employer____
_
Employer Address____
Employer Telephone_______________________
Referred By____

2. Billing Information

Person responsible for payment of bill (if different from above)_________________
Address____________________________ **City**____________ **State**_____ **Zip**______
Date of Birth_________________ **Relationship to Client**______________________
Home Telephone (   ) _____________ Work Telephone (   ) _________________
Employer____

3. Insurance Information
Primary Medical Insurance Company
____
Address for sending claims____
ID Number____________ **Group Number**_____________ **Telephone**_____________
Deductible?________ **Now much?**_______ **Co Pay?**________
Effective date of coverage__________________________________

Secondary Medical Insurance Company
____
Address for sending claims____
ID Number____________ **Group Number**___________ **Telephone**_______________
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4. Assignment of Benefits
I hereby assign mental health/psychotherapy benefits to which I am entitled (including Medicare, private insurance, and other health plan benefits) to The Integral Psychology Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original copy. I understand that I am financially responsible for all charges. I hereby authorize said assignee (The Integral Psychology Center) to release all information necessary to secure payment on my behalf.

_____________________________________ **Date**____________________
Signature of Client and/or Responsible Person